BUREAU OF MEDICINE AND SURGERY
RESERVE FORCES DENTAL EXAMINATION

Form Approved

Expires

PRIVACY ACT STATEMENT

AUTHORITY:

PRINCIPAL PURPOSE(S): An assessment by a dentist of the state of your dental health for the next 12 months is needed to determine your fitness for prolong duty without ready access to dental care.

ROUTINE USE(S): None.

DISCLOSURE: Voluntary; however, failure to provide the information may result in delays in assessing your dental health needs for military service.

1. SERVICE MEMBER'S NAME *(Last, First, Middle Initial)*	2. SOCIAL SECURITY NUMBER	3. BRANCH OF SERVICE

4. UNIT OF ASSIGNMENT	5. UNIT ADDRESS

6. EXAMINATION RESULTS

Dear Doctor,

The individual you are examining is a Guard/Reserve member of the United States Armed Forces. This member needs your assessment of his/her dental health for worldwide duty. Please mark (X) the block that best describes the condition of the member, using as a suggested minimum of clinical examination with mirror and probe, and bitewing radiographs. This form is meant to determine fitness for prolong duty without ready access to dental care and is not intended to address the member's comprehensive dental needs. (Note: If bitewings were taken for this examination please attach a duplicate copy of the x-rays to this form.)

		(1) Patient has good oral health and is not expected to require dental treatment or reevaluation for 12 months.
		(2) Patient has some oral conditions, but you do not expect these conditions to result in dental emergencies within 12 months if not treated (i.e., requires prophylaxis, symptomatic caries with minimal extension into dentin, edentulous areas not requiring immediate prosthetic treatment).
		(3) Patient has oral condition that you do expect to result in dental emergency within 12 months if not treated.
		(a) Infections: Acute oral infection s, pulpal or periapical pathology, chronic oral infections, or other pathologic lesions and lesions requiring biopsy report.
		(b) Caries/Restorations: Dental caries or fractures with moderate or advanced extension into dentin; defective restorations or temporary restorations that patient cannot maintain for 12 months.
		(c) Missing Teeth: Edentulous areas requiring immediate prosthodontic treatment for adequate mastication, communication, or acceptable esthetics.
		(d) Peridontal Conditions: Acute gingivitis or pericoronitis, active moderate to advanced periodontis, periodontal abscess, progressive mucogingival condition, moderate to heavy subgingival calculus, or periodontal manifestations of systemic disease or hormonal disturbances.
		(e) Oral Surgery: Unerupted, partially erupted, or malposed teeth with historical, clinical, or radiographic signs or symptoms or pathosis that are recommended for removal.
		(f) Other: Temporomandibular disorders or myofasical pain dysfunction requiring active treatment.

(4) If you selected block (3) please indicate the dental condition that requires treatment on the reverse side of this form.

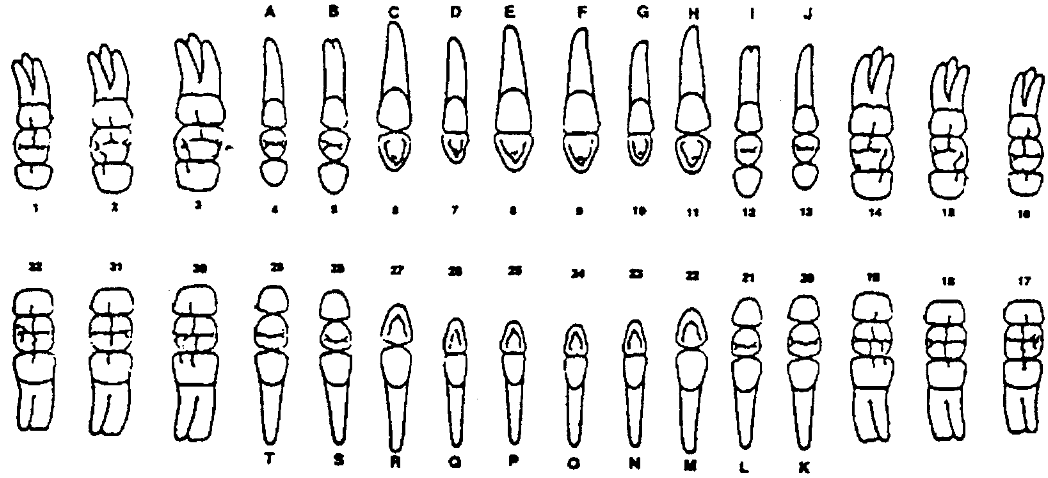
(5) Were X-rays Consulted?		YES		NO	IF YES, DATE X-RAY WAS TAKEN *(YYYYMMDD)*

7. DENTIST'S NAME *(Last, First, Middle Initial)*	8. DENTIST'S ADDRESS *(Include Zip Code)*
9. DENTIST'S TELEPHONE NUMBER *(Include Area Code)*	

10. DENTIST SIGNATURE	11. DATE OF EXAMINATION *(YYYMMDD)*

2813 (BUMED Trial)

Examination Dental Disease and Abnormalities
PEN ENTRIES ONLY



DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, PROVIDER, TRATMENT FACILITY *(Sign each entry)*	CLASS
	S: Annual Exam	
	O: T-2; BWX Y N HQR Reviewed	
	A: Perio:	
	Oper:	
	Endo:	
	OS:	
	Phase 1 (Urgent) Phase 2 (Routine)	
	P: Perio:	
	Oper:	
	Endo:	
	OS:	

PATIENT'S NAME:	SSN: